

When Is an Unusual Sexual Interest a Mental Disorder?

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Blanchard et al.'s (2008) excellent article distinguishing Hebephilia (erotic arousal to pubescent children) from Pedophilia (erotic arousal to prepubescent children) raises an important issue. In the article, Blanchard et al. specifically advocate incorporating Hebephilia into the forthcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association (APA). I am not challenging their conclusion that sexual interests in pubescent and prepubescent minors are distinct entities (albeit with some overlap) or that the distinction may have utility for research purposes, but it is not clear that a sexual interest in pubescent minors implies that the individual suffers from a mental disorder, specifically a Paraphilia. Blanchard et al. may assume that Hebephilia will meet the other criteria required for a Paraphilia diagnosis and a mental disorder, but that is neither obvious nor necessarily true.

To be crystal clear, the following comments should *not* be construed as supportive of any sexual activity between adults and minors in any way. Having sex with a minor is a crime and should be punished as such, but it is not clear that this behavior constitutes a mental disorder.

How we conceptualize a problem is important. Are the problems associated with an unusual sexual interest primarily sexual, related to another mental disorder, or are they

social rather than psychiatric? There is no doubt that some people experience problems related to their sexual interests or behavior, but the sex can be a manifestation of another disorder rather than the cause of the problem. Compulsively washing one's hands can be a symptom of Obsessive-Compulsive Disorder, but it is not a hand washing disorder. The treatment and conceptualization of unusual sexual interests as Paraphilias have not led to greater understanding of, or more effective treatment for, individuals with these interests; some would argue that pathologizing unusual sexual interests has led to more discrimination and discouraged individuals from seeking treatment for any problem (see Klein & Moser, 2006; Kleinplatz & Moser, 2004; Kolmes, Stock, & Moser, 2006).

Paraphilia diagnoses have been misused in criminal and civil proceedings as an indication that these individuals cannot control their behavior. Although there is some indication in the *DSM* (see APA, 2000, p. 663) that the Paraphilias are Impulse Control Disorders, impulse control is not mentioned in the Paraphilia diagnostic criteria. At least from my experience, most individuals with unusual sexual interests are quite capable of controlling their behavior and, in fact, do so. Those individuals who cannot control their sexual impulses may qualify for another diagnosis based upon their inability to control their impulses, but not based upon the specific sexual behavior. The *DSM* specifically notes the "...Paraphilias... are not considered to be compulsions..." (APA, 2000, p. 462); "compulsive masturbators" and "compulsive homosexuals" began to disappear once those behaviors were no longer seen as signs or symptoms of psychopathology.

I have been quite critical of the Paraphilias diagnostic category in the past (Kleinplatz & Moser, 2005; Moser, 2001, 2002; Moser & Kleinplatz, 2002, 2005a, 2005b) and will not repeat those criticisms here. I will question another aspect of

Editor's note: This letter was submitted to the *Journal* after Blanchard's reply to the other letters about the Blanchard et al. (2008) article was in production; hence, the reply by Blanchard (2008) does not refer to the content of this letter.

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diagnosis, that is, whether those diagnosed with a Paraphilia diagnosis exhibit a particular type of dysfunction.

The “B” criterion of all the *DSM-IV-TR* (APA, 2000, pp. 569–575) Paraphilia diagnoses state either that the sexual interest causes “...clinically significant distress or impairment in ... functioning” or “... marked distress or interpersonal difficulty.” (No rationale is given for the different phrasing.) For brevity, I will refer to this as the dysfunction resulting from the “disorder,” which is an essential part of definition of all mental disorders (see APA, 2000, p. xxxi). For completeness, the criminal Paraphilias (e.g., Exhibitionism, Frotteurism, Pedophilia, Voyeurism, and Sexual Sadism with a nonconsenting person) allow that acting on the interest is enough to satisfy the “B” criterion, but more about that later.

The dysfunction associated with one mental disorder usually differs from the dysfunction associated with another disorder. The dysfunction resulting from depression is different than anxiety, which, in turn, is different from the dysfunction resulting from schizophrenia, which is different from that seen with Obsessive-Compulsive Disorder, etc. So the question becomes: How does the dysfunction associated with the Paraphilias manifest? It needs be different from other diagnostic categories or the other diagnoses would be more appropriate. Even if 100% of individuals with a specific sexual interest are clinically depressed, the dysfunction associated with depression requires making a depression diagnosis, not a Paraphilia diagnosis. The characteristic Paraphilia dysfunction, whatever that might be, would need to be present in order to make the additional Paraphilia diagnosis. The dysfunction related to the Paraphilia diagnosis should be unique to the Paraphilias and distinct from those with “normal” (whatever that actually constitutes) interests. Moser and Kleinplatz (2005a, b) have shown that the current *DSM* (APA, 2000) diagnostic criteria do not distinguish individuals with a paraphilia from those with “normal” sexual interests. Unusual sexual interests are often blamed inappropriately (and diagnosed incorrectly) for other problems (see Moser & Kleinplatz, 2002). Just having an unusual sexual interest is not pathological anymore than having an unusual hair color is; the interest must cause the dysfunction to be a mental disorder.

I am sure that some people will point out immediately that many of the Paraphilias are crimes against nonconsenting individuals or individuals legally incapable of giving consent, but just committing a crime does not indicate psychopathology and most criminals do not have diagnoses based upon their specific crimes. There are also real concerns that some governments (and mental health professionals) use psychiatric diagnoses to criminalize, marginalize, and pathologize variant behavior inappropriately. Dissidents, political and sexual, have been “interned” in psychiatric hospitals, obviously “crazy” to oppose the government or

societal mores. Remember, African slaves were once thought to suffer from drapetomania, a mental disorder that led them to run away from their masters (Harris, Felder, & Clark, 2004).

Which sex crimes are diagnoses is actually quite confusing. Some sex crimes are not diagnoses (e.g., rape) and some Paraphilia diagnoses are not crimes (e.g., Fetishism, Sexual Masochism, consensual Sexual Sadism, and Transvestic Fetishism). Some sexual interests were both crimes and diagnoses, but are no longer (e.g., homosexuality). Some used to be just diagnoses, but are no longer (e.g., nymphomania), though some would like to resurrect the hypersexuality diagnoses (see Kafka & Hennen, 1999). Some current sexual diagnoses were thought to be normal in the past, but are now diagnoses or proposed diagnoses (e.g., female sexual arousal disorder, female orgasmic disorder, and hebephilia). Some sexual behaviors were psychiatric disorders and were believed to cause a variety of physical disorders, but are now considered healthy (e.g., masturbation). Some sexual diagnoses have “evolved” from primarily psychological to physiologic causation (e.g., erectile dysfunction). What is defined as “normal” sexual behavior, what is a mental disorder, what is a crime, and what constitutes a sex crime do change over time. Psychiatry should be acutely aware of its history; psychiatrists have been responsible for institutionalizing far too many individuals for violating cultural (and especially sexual) norms. I hope the *DSM-V* editors will adhere to the goal of basing diagnoses on empirical science and not just support current social or cultural conventions.

Our society seems fixated on certain types of sexual interests. Age of one’s sex partner seems to be the most prevalent focus at this time. Even if not a crime or a mental disorder, preferring much older or younger sex partners leaves one open to derision. An 80-year-old with a 20-year-old (of any combination of sexes) makes the skin of many individuals crawl. This leads to a lot of speculation (and a few research studies) to identify why this occurs and how to avoid it in the future. In Blanchard et al.’s current study, they question if one can distinguish pedophiles from hebephiles, but do not seem interested if similar techniques can distinguish if a 45-year-old prefers 25-year-olds, 45-year-olds, or even 65-year-olds. Can one distinguish a preference for legs over breasts, large breasts over small breasts, slight over muscular, hirsute over smooth, or blondes over brunettes? If Blanchard et al.’s technique shows a difference between these characteristics, what does that mean, especially considering how a response to pubescent individuals will be used by our legal system?

Blanchard et al.’s subjects were mostly individuals who admitted to their crimes, but any interest (possibly slight) to a minor may condemn an innocent. Imagine a man (they are almost always men) who admits or is measured to have some sexual interest in pubescent children, who is now *falsely*

accused. He now has a mental disorder that implies he is a danger to our children. Will he lose the benefit of the doubt, as some believe it is just a matter of time before he will offend? After all, in these cases, one could argue that we must err to protect our children, even though most of us have sexual fantasies we have no intention of acting upon. Is the era of the thought crime upon us? I hasten to add that Blanchard et al. have not suggested any of this, but it is where incorporating Hebephilia into the *DSM* is leading us.

Historically, we have been obsessed (and I am not using that term lightly) with the sex of one's sexual partners, their religion, their station in life, their income, their fecundity, whether one's parents were legally married at the time of birth, whether one masturbates, etc. Now we are obsessed with the desired age of one's partner, but does that imply a mental disorder? Again, I do not doubt that some individuals have sexual preferences for certain aged partners. The question is why is this important to enshrine into the *DSM*? Why is a preference for blonde age-mates less important?

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